

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 15 1934

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis**

(No. **Deaconess Hosp.**)

File No. **27359**

Registered No. **7602**

St. Ward)

2. FULL NAME **Archibald Williamson**

(a) Residence, No. **2304 Big Bend St.** **NR** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Hattie B.**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **12-10-1866**

7. AGE YEARS **67** MONTHS **7** DAYS **15** If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Druggist** 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **Physician** 10. Date deceased last worked at this occupation (month and year) **11** Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) **Evansville** (STATE OR COUNTRY) **Ind.**

MOTHER 13. NAME **Randerson Williamson**

14. BIRTHPLACE (CITY OR TOWN) **Ill.** (STATE OR COUNTRY)

15. MAIDEN NAME **Hannah Hill**

16. BIRTHPLACE (CITY OR TOWN) **Ill.** (STATE OR COUNTRY)

17. INFORMANT **Hattie B. Williamson** (ADDRESS) **2304 Big Bend**

18. BURIAL, CREMATION, OR REMOVAL **Valhalla** DATE **7-27-1934**

19. UNDERTAKER **Alexander & Sons** (ADDRESS) **617 S. 3rd St.**

20. FILED **ULL 20 1934** **J. Brebeck** Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **July 25, 1934**

22. I HEREBY CERTIFY, That I attended deceased from **July 10** 19**34** to **July 25** 19**34** I last saw him alive on **July 25** 19**34** Death is said to have occurred on the date stated above, at **5:30 P.** m.

The principal cause of death and related causes of importance were as follows:

Acute Myocarditis
Carcinoma of Pancreas

Other contributory causes of importance

Name of operation **Laparotomy (Exploratory)** of **12/23/34**

What test confirmed diagnosis? **Clinical** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify (Signed) **Arthur M. Westrich** M. D.

(Address) **2046 Big Bend Webster St. Mo.**

204 E. Big Bend.